Child and Adult Care Food Program (CACFP) Claim for Reimbursement

1. Agreement Number:	CACFP #:
	NSLP #:

Place an "X" in this box if this is an adjusted claim:	

2. Organization Contact Information			
Name:			
Street Address:			
City:			
State:		ZIP Code:	
Name of Contact:			
Contact Telephone #:			

3. Claim Period:	Month:		Year:	
4. Number of Food Service Operating Days:				

5. COMPLETE IF PROGRAM TYPE a - h: Total Participants in Each Eligibility Category for This Claim Period
Note: All participants at emergency shelters are classified as "Free."

Free	Reduced-Price	Paid

6. Total Number of Program Types Operated in This Claim Period	
	a. CCC
	b. OSCHC
	c. Head Start
	d. TXX CCC
	e. ADC
	f. TXIX ADC
	g. TXX ADC
	h. Shelter
	i. At-Risk Snack
	j. At-Risk Breakfast/Lunch/Supper

7. Total Attendance	
	a. CCC
	b. OSCHC
	c. Head Start
	d. TXX CCC
	e. ADC
	f. TXIX ADC
	g. TXX ADC
	h. Shelter
	i. At-Risk Snack
	j. At-Risk Breakfast/Lunch/Supper

8. Average Daily Attendance	
	a. CCC
	b. OSCHC
	c. Head Start
	d. TXX CCC
	e. ADC
	f. TXIX ADC
	g. TXX ADC
	h. Shelter
	i. At-Risk Snack
	j. At-Risk Breakfast/Lunch/Supper

9. COMPLETE IF PROGRAM TYPE a – h: Total Number of Meals Served by Meal Type During This Claim Period

Breakfast	A.M. Snack	Lunch	P.M. Snack	Supper

10. FOR AT-RISK PROGRAMS ONLY: Total Participants and Meals Served During This Claim Period

Number of Participants Served an At-Risk Snack:		Total Number of At-Risk Snacks Served:	
Number of Participants Served an At-Risk Breakfast:		Total Number of At-Risk Breakfasts Served:	
Number of Participants Served an At-Risk Lunch/Supper:		Total Number of At-Risk Lunches/Suppers Served:	

11. Other Notes:

I certify that to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim, that is in accordance with the terms of existing Agreements(s); I recognize that I will be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. I further certify that claims submitted for meals served in Proprietary TXIX Adult Day Care Centers and Proprietary TXX Child Day Care and Adult Day Care Centers are submitted only for those individual centers having 25% or more participants receiving Title XIX/Title XX benefits enrolled for this claim period. I further certify that this claim and/or addendum submitted for meals served shall be submitted to the State Agency by the 10th of the month, but no later than the legislatively mandated deadline of 60 days after the end of the claim month. I understand that failure to submit claims within the 60 days may result in such claims not being paid.

All receipts, invoices and other evidence of purchase must be retained and available for future audits for a period of three years after the date of the final submission of the final claim for the fiscal year to which they pertain, or longer if related to an audit or investigation in progress.

No further monies or other benefits may be paid out under the program unless this report is completed and filed as required by existing regulations (7 CFR 226).

Print Name of Authorized Representative	Title	Signature of Authorized Representative	Date